

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

2225-62-008063
STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

Registration District No. **318** Primary Registration District No. **1003** Registrar's No. _____

FILED FEB 28 1962					
1. PLACE OF DEATH					
a. COUNTY _____					
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis					
Length of stay in lb 4mo.					
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Chronic Hosp.					
Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>					
2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)					
a. STATE Mo. b. COUNTY _____					
c. CITY OR TOWN St. Louis					
Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>					
d. STREET ADDRESS (If outside, give location) 4351 Cote Brillante					
Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>					
3. NAME OF DECEASED First Middle Last			4. DATE OF DEATH Month Day Year		
Thelma Frisby			2-21-62		
5. SEX Female		6. COLOR OR RACE Col.		7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	
8. DATE OF BIRTH 5/5/96		9. AGE (last birthday) 65		IF UNDER 1 YEAR IF UNDER 24 HR	
				Months 9 Days 16 Hours _____ Min. _____	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife			10b. KIND OF BUSINESS OR INDUSTRY None		
11. BIRTHPLACE (City and state or country) Fla.			12. CITIZEN OF WHAT COUNTRY U.S.A.		
13a. FATHER'S NAME Lloyd			13b. MOTHER'S MAIDEN NAME unk.		
14. NAME OF HUSBAND OR WIFE Peter E. Frisby					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Address Peter E. Frisby, 4351 Cote Brill.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:					
IMMEDIATE CAUSE (a) PNEUMONITIS, Secondary to METASTATIC CARCINOMA					
DUE TO (b) CARCINOMA, LEFT BREAST.					
DUE TO (c) 170x					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) ANEMIA - ARTERIOSCLEROTIC HEART DISEASE					
PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown					
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)	
20c. TIME OF INJURY Hour _____ a.m. _____ p.m.		Month, Day, Year _____			
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		20f. CITY, TOWN, OR LOCATION COUNTY STATE	
21. I attended the deceased from 9-18-61 to 2-21-62 and last saw her/him alive on 2-21-62					
Death occurred at 4:35 a.m. on the date stated above, and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE (Degree or title) John J. Kenney M.D.			22b. ADDRESS 5800 Arsenal Ave		22c. DATE SIGNED 2-21-62
23a. BURIAL-CREATION, REMOVAL (Specify) Removal		23b. DATE 2/27/62	23c. NAME OF CEMETERY OR CREMATORY Greenwood Cemetery		23d. LOCATION (City, town, or county) (State) St. Louis, Missouri
24. FUNERAL DIRECTOR ADDRESS Chas. J. Gates, Jr., 4107 Finney			25. DATE RECD. BY LOCAL REG. FEB 24 1962		26. REGISTRAR'S SIGNATURE Loan Smith, M.D.

VS 300 Rev. 4/59

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DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

DOCUMENT

MEDICAL CERTIFICATION

SHOULD READ

BY AFFIDAVIT OF

USE BLACK INK OR TYPEWRITER RIBBON

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STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,
or by _____, Student Embalmer No. _____
working under my personal supervision.

+ Student _____
Signature of Student Embalmer.

Signed Gupton Swan

Licensed Embalmer No. 4580

P. O. Address 4107 Finney

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).

If embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.